DPH/HSP Office Use Only			
Date Received	_____	Physician Verified in Good Standing?	
Staff Initials	_____	Yes	_____
Date Verified	_____	No	_____
Staff Initials	_____		

PHYSICIAN CERTIFICATION

PATIENT'S INSTRUCTIONS: Have your physician complete this entire section (pages 4-5). This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Division of Public Health Medical Marijuana Office, within 90 days of the physician's signature date.**
Faxed and electronic copies will not be accepted.

NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR MARIJUANA.

PHYSICIAN'S INSTRUCTIONS: Print clearly and answer all of the questions with information in the patient's medical record.

PATIENT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:** *(Must be 18 or Older)*
Address: *(Street)*		
Address: *(P.O. Box, Apt. #)*		
Address: *(City, State, ZIP Code)*		
Primary Phone:	**Length of time patient has been under your care?**	

DEBILITATING MEDICAL CONDITION

Listed below are the ONLY qualifying debilitating medical conditions as stated in Title 16 of the Delaware Code, 4902A (3)
☐ Cancer
☐ Positive status for Human Immunodeficiency Virus (HIV Positive)
☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Decompensated Cirrhosis (Hepatitis C)
☐ Amyotrophic Lateral Sclerosis (ALS / Lou Gehrig's Disease)
☐ Agitation of Alzheimer's Disease
☐ Post-traumatic Stress Disorder (PTSD) ***Note: MUST be a licensed psychiatrist to certify for this condition.***
☐ A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following ***(Specify in comments)***:
☐ Cachexia or Wasting Syndrome
☐ Severe, debilitating pain that has not responded to previously prescribed medication or surgical measure for more than three (3) months, or for which other treatment options produced serious side effects.
☐ Intractable Nausea
☐ Seizures
☐ Severe and persistent muscle spasms, including but not limited to those characteristic of Multiple Sclerosis
Comments: Provide any additional information that would be useful in assessing this patient's application to the Delaware Medical Marijuana Program.

DPH/HSP Office Use Only

Date Requested	_____	Patient Verified with Certifying Physician(s)?	
Staff Initials	_____	Yes	_____
Date Verified	_____	No	_____
Staff Initials	_____		

PHYSICIAN CERTIFICATION (CONTINUED)

PHYSICIAN INFORMATION

Name: *(Title, First, MI, Last, Suffix)*		**Medical License Number:**
Address: *(Street)*		**License State:** *(Must be licensed in Delaware)*
Address: *(P.O. Box, Apt. #)*		**License Type:** *(Must be DO or MD)*
Address: *(City, State, ZIP Code)*		
Phone:	**Fax:**	**Email:** *(not required)*

PHYSICIAN CERTIFICATION

I have made or confirmed a diagnosis of a debilitating medical condition, as defined in Title 16, Chapter 49A of the Delaware Code (4902A(3)), for the qualifying patient. _____ *Physician Initials*

I have established a bona fide physician-patient relationship with _____, (patient) beginning _____ (date of first patient visit to your office). This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form. _____ *Physician Initials*

I have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed. _____ *Physician Initials*

I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians for the qualifying condition. I have established a medical record of the qualifying patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical marijuana treatment. _____ *Physician Initials*

I have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient. _____ *Physician Initials*

Physician's Attestation

I _____, (physician), hereby certify that I am a physician duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's qualifying debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.
I attest that the information provide in this written certification is true and correct.

_____ Physician's Signature (no signature stamps accepted)

_____ Date